

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Form Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. AISME  
5M 7/59

1

13816

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13767

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Near Cambridge</b> c. LENGTH OF STAY IN lb <b>3yrs.+</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Eastern Shore State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>107 Fooks street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DANIEL LEE BAILEY</b>		4. DATE OF DEATH Month Day Year <b>December 3rd. 1960 19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/10/81</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Hilery Bailey</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Parsons</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs. Harry Morris (Daughter) Melson, Md</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerotic cardio-vascular renal disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinson's Synd. &amp; Inter-trochanteric fracture Femur, Left (11/23/60)</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <b>Deceased slipped on the floor and fractured his hip.</b>	
20b. TIME OF INJURY Month, Day, Year <b>11/23/60</b>		20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>E.S.S. Hospital</b>		20e. (City or town) (County) (State) <b>nr. Cambridge, Dorchester, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Eldridge H. Wolff</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Eldridge H. Wolff, M. D. Cambridge, Maryland</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 7, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		22d. LOCATION (City, town, or country) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>DEC 6 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kears</b>	

MEDICAL CERTIFICATION

DATE SIGNED  
12/3/60

41281

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13817

Item 1 Film 6278 1-4 61 et

CERTIFICATE OF DEATH

13770

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) rural Cambridge		c. LENGTH OF STAY IN lb 4Ys 9Mos. 15Dys		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Michaels		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS 20X-J							
3. NAME OF DECEASED (Type or print) Nettie OLivia Callis		First		Middle		Last		4. DATE OF DEATH Dec 23 1960		Month Day Year	
5. SEX F		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 8 1872		9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Md		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Henry Burrows				14. MOTHER'S MAIDEN NAME Fannie Burrows SEARS							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 120		17. INFORMANT Hospital records Cambridge Md		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 general Arteriosclerosis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH UNK	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from March 8, 1956, to Dec 23, 1960, that (I) (we) last saw the deceased alive on Dec 23, 1960, and that death occurred at 8:30 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Thomas J. Dredge				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec 23 '60	
22c. PHYSICIAN'S NAME (Type) Thomas J. Dredge				22d. ADDRESS E.S.S. Hospital, Cambridge, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-26-60		23c. NAME OF CEMETERY OR CREMATORY Telchman Cemetery		23d. LOCATION (City, town, or county) Telchman Ind		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE St. Vincent Harris				ADDRESS St. Michaels		25a. REC'D BY REGISTRAR DATE DEC 28 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

STAFFORD, THE NATIONAL STATE CHARTER  
 ASSOCIATION, INC. 10000 10000 10000 10000 10000  
 STAFFORD, THE NATIONAL STATE CHARTER  
 ASSOCIATION, INC. 10000 10000 10000 10000 10000





THE STATE  
DEPT. OF HEALTH

13818

13818 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1922

NEW MARKET, 222 1/2 EAST 4th STREET

MD

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WILLIAM HOWARD CHRISTMAN 11-12-12

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From Cause of Death in the Community  
DEATH CERTIFICATE

Community - 11-12-12

11-12-12

11-12-12

11/12/12

JOHN MARSH

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
13819 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13772										
Item 4 Film 6277 12-27-60 et										
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ragged Point RFD 3</b> c. LENGTH OF STAY IN lb <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>None</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ragged Point, RFD 3</b> d. STREET ADDRESS <b>None</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>William H. Cook</b>					4. DATE OF DEATH Month Day Year <b>12 12 1960</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/2/1889</b>		9. AGE (In years last birthday) <b>71</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Waterman</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland, Dorchester, Co.</b>		
13. FATHER'S NAME <b>Wilda Cook</b>					14. MOTHER'S MAIDEN NAME <b>Lavra Hubbard</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>No</b>					
17. INFORMANT <b>Mrs. Arthur Cook, R.F.D.# 3, Cambridge, Md.</b>					Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>John Mace Jr.</b> EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12/19/60</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>12/17/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Speddens Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Cambridge, Md. R.F.D# 3</b>	
23. FUNERAL DIRECTOR <b>Le Compte Funeral Service, Cambridge, Md.</b>					24a. REC'D BY REGISTRAR DATE <b>DEC 22 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hance</b>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13797 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13773											
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>entire life</b>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>410 Maryland Ave.</b>				d. STREET ADDRESS <b>410 Maryland Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Minnie</b>				4. DATE OF DEATH <b>December 1, 1960</b>				5. SEX <b>Female</b>			
6. COLOR OR RACE <b>White</b>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>September 15, 1876</b>			
9. AGE (In years last birthday) <b>84 yrs.</b>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				11. BIRTHPLACE (State or foreign country) <b>Vienna district</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				13. FATHER'S NAME <b>William Henry Corkran</b>				14. MOTHER'S MAIDEN NAME <b>Emma S. Reid</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Mrs. Harry K. Stoker, 410 Maryland Ave., Camb, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>Cambridge</b>				20g. (County) <b>Cambridge</b>				20h. (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12/3/60</b> ACTUAL SIGNATURE <b>John Mace Jr.</b> EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b> Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Dec. 3, 1960</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery</b>			
22d. LOCATION (City, town, or country) <b>Cambridge, Md.</b>				22e. (State) <b>Md.</b>				24a. REC'D BY REGISTRAR <b>DEC 15 '60</b>			
23. FUNERAL DIRECTOR <b>Herbert A. Thomas</b>				23b. ADDRESS <b>Cambridge, Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **13774**

**13798**

1. PLACE OF DEATH o. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>220B Muir Street</b>				d. STREET ADDRESS <b>220B Muir Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Cornish</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>9</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 11, 1883</b>	9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min.	IF UNDER 24 HRS. Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>			
11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Caleb Molock</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Stanley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>George Cornish, Cambridge, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>November 1 1959</b> , to <b>Dec 9 1960</b> , that I last saw the deceased alive on <b>December 9 1960</b> , and that death occurred at <b>8 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>227 Pine St-Cambridge, Md.</b> DATE SIGNED <b>12-12-60</b> ACTUAL SIGNATURE <b>J. Edwin Fassett, M.D.</b> M.D. <b>227 Pine St-Cambridge, Md.</b> <b>12-12-60</b> PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>12/13/1960</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Waugh Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard H. Fassett</b>				24a. REC'D BY REGISTRAR <b>DATE DEC 21 '60</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED George Joseph Campbell, Jr.		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 1911		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Salesman		7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF DEATH Home		10. DATE OF DEATH 1946	
11. SIGNATURE OF DECEASED George Joseph Campbell, Jr.		12. SIGNATURE OF WITNESS Elizabeth Stanley		13. SIGNATURE OF PHYSICIAN [Signature]		14. SIGNATURE OF CLERK [Signature]		15. SIGNATURE OF REGISTRAR [Signature]	
16. ADDRESS OF DECEASED [Address]		17. ADDRESS OF WITNESS [Address]		18. ADDRESS OF PHYSICIAN [Address]		19. ADDRESS OF CLERK [Address]		20. ADDRESS OF REGISTRAR [Address]	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDES.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 13775

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hospital</b>		e. STREET ADDRESS <b>38 Park Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Joseph</b> Last <b>Cornish</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>26</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1909</b>
9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Cambridge, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Cornish</b>		14. MOTHER'S MAIDEN NAME <b>Eva Cornish</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-----</b>		16. SOCIAL SECURITY NO. <b>214-07-8371</b>	
17. INFORMANT <b>Jehu Wilson, Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Hemorrhage</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-----</b> DUE TO (c) <b>-----</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 29, 1960</b> , to <b>Dec 26, 1960</b> , that I last saw the deceased alive on <b>December 26, 1960</b> , and that death occurred at <b>8 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>227 Pine St., Cambridge, Md.</b> DATE SIGNED <b>12-30-60</b> ACTUAL SIGNATURE <b>J. Edwin Fassett, M.D.</b> PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/30/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard M. Wallace Jr.</b> ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 3 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

13700

1. NAME OF DECEASED JAMES WILSON		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1885	
5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. DATE OF DEATH 1950	
9. CAUSE OF DEATH Heart Disease		10. PLACE OF DEATH Home		11. SIGNATURE OF PHYSICIAN J. H. Smith		12. SIGNATURE OF REGISTRAR J. H. Smith	
13. NAME OF FUNERAL HOME J. H. Smith		14. ADDRESS OF FUNERAL HOME 123 Main St.		15. CITY Baltimore		16. STATE Md.	
17. NAME OF NEXT OF KIN J. H. Smith		18. ADDRESS OF NEXT OF KIN 123 Main St.		19. CITY Baltimore		20. STATE Md.	
21. NAME OF WITNESS J. H. Smith		22. ADDRESS OF WITNESS 123 Main St.		23. CITY Baltimore		24. STATE Md.	
25. NAME OF WITNESS J. H. Smith		26. ADDRESS OF WITNESS 123 Main St.		27. CITY Baltimore		28. STATE Md.	
29. NAME OF WITNESS J. H. Smith		30. ADDRESS OF WITNESS 123 Main St.		31. CITY Baltimore		32. STATE Md.	
33. NAME OF WITNESS J. H. Smith		34. ADDRESS OF WITNESS 123 Main St.		35. CITY Baltimore		36. STATE Md.	
37. NAME OF WITNESS J. H. Smith		38. ADDRESS OF WITNESS 123 Main St.		39. CITY Baltimore		40. STATE Md.	
41. NAME OF WITNESS J. H. Smith		42. ADDRESS OF WITNESS 123 Main St.		43. CITY Baltimore		44. STATE Md.	
45. NAME OF WITNESS J. H. Smith		46. ADDRESS OF WITNESS 123 Main St.		47. CITY Baltimore		48. STATE Md.	
49. NAME OF WITNESS J. H. Smith		50. ADDRESS OF WITNESS 123 Main St.		51. CITY Baltimore		52. STATE Md.	
53. NAME OF WITNESS J. H. Smith		54. ADDRESS OF WITNESS 123 Main St.		55. CITY Baltimore		56. STATE Md.	
57. NAME OF WITNESS J. H. Smith		58. ADDRESS OF WITNESS 123 Main St.		59. CITY Baltimore		60. STATE Md.	
61. NAME OF WITNESS J. H. Smith		62. ADDRESS OF WITNESS 123 Main St.		63. CITY Baltimore		64. STATE Md.	
65. NAME OF WITNESS J. H. Smith		66. ADDRESS OF WITNESS 123 Main St.		67. CITY Baltimore		68. STATE Md.	
69. NAME OF WITNESS J. H. Smith		70. ADDRESS OF WITNESS 123 Main St.		71. CITY Baltimore		72. STATE Md.	
73. NAME OF WITNESS J. H. Smith		74. ADDRESS OF WITNESS 123 Main St.		75. CITY Baltimore		76. STATE Md.	
77. NAME OF WITNESS J. H. Smith		78. ADDRESS OF WITNESS 123 Main St.		79. CITY Baltimore		80. STATE Md.	
81. NAME OF WITNESS J. H. Smith		82. ADDRESS OF WITNESS 123 Main St.		83. CITY Baltimore		84. STATE Md.	
85. NAME OF WITNESS J. H. Smith		86. ADDRESS OF WITNESS 123 Main St.		87. CITY Baltimore		88. STATE Md.	
89. NAME OF WITNESS J. H. Smith		90. ADDRESS OF WITNESS 123 Main St.		91. CITY Baltimore		92. STATE Md.	
93. NAME OF WITNESS J. H. Smith		94. ADDRESS OF WITNESS 123 Main St.		95. CITY Baltimore		96. STATE Md.	
97. NAME OF WITNESS J. H. Smith		98. ADDRESS OF WITNESS 123 Main St.		99. CITY Baltimore		100. STATE Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13820

CERTIFICATE OF DEATH

Reg. Dist. No. 13776

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CAMBRIDGE</u>		c. LENGTH OF STAY IN 1b <u>2 MOS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH C. COSTEN</u>		4. DATE OF DEATH Month Day Year <u>DEC. 20 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 6, 1885</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>ISAAC THOMAS COSTEN</u>		14. MOTHER'S MAIDEN NAME <u>OLIVIA ADAMS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>OLIVIA COSTEN</u>		Address <u>CITY, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRAGE</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 MOS. +</u> <u>3 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT. 20</u> , 19 <u>60</u> , to <u>DEC. 20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>DEC. 17</u> , 19 <u>60</u> , and that death occurred at <u>10:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>George H. Longley</u> M.D. <u>RFD 2, CAMBRIDGE, MD.</u> <u>12/20/60</u>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>GEORGE H. LONGLEY</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-23-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PITTS CREEK PRESBYTERIAN</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		ADDRESS <u>POCOMOKE CITY, MD.</u>	
24a. REC'D BY REGISTRAR <u>DEC 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

1875

CERTIFICATE OF DEATH

1875

Blank certificate form with horizontal lines for text entry.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. Give Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

13821

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13777

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Columbia</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Vienna - Rural</b>		c. LENGTH OF STAY IN lb <b>6½ hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Indiantown Road</b>			d. STREET ADDRESS <b>211 Sixth Street, S.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Archie</b> Middle <b>Leroy</b> Last <b>Craver</b>			4. DATE OF DEATH Month <b>December</b> Day <b>3</b> Year <b>19 60</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 1, 1906</b>		9. AGE (In years last birthday) <b>54 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electrical</b>		11. BIRTHPLACE (State or foreign country) <b>Greensboro, N.C.</b>	
13. FATHER'S NAME <b>Roy G. Craver</b>			14. MOTHER'S MAIDEN NAME <b>Martha Susan Myers</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW II</b>		16. SOCIAL SECURITY NO. <b>578-24-4172</b>		17. INFORMANT <b>Theodore G. Craver, Alexandria, Virginia</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>p. m.</b> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>John Mace, Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Dec. 3, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 7, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b>		(State) <b>Virginia</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>		ADDRESS <b>Federalsburg, Maryland</b>		24a. REC'D BY REGISTRAR <b>DEC 6 '60</b>	





13822 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No. 13778

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Somerset</b> b. COUNTY <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield, Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		d. STREET ADDRESS <b>--</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Dorman</b> Last <b>Dorman</b>		4. DATE OF DEATH Month <b>December</b> Day <b>29</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-14-75</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>19</b> Hours <b>60</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jimmy Dorman</b>		14. MOTHER'S MAIDEN NAME <b>Madeline Batcher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO. <b>--</b>	
INFORMANT <b>Eastern Shore State Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>General Arteriosclerosis</b> DUE TO (b) <b>General Arteriosclerosis</b> (c) <b>Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-1</b> , 19 <b>57</b> , to <b>12-29</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12-29</b> , 19 <b>60</b> , and that death occurred at <b>4:42 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Ettore DeFilippis</b> M.D.		Eastern Shore State Hospital Cambridge, Maryland	
PHYSICIAN'S NAME (Type) <b>Ettore DeFilippis, M.D.</b>		<b>12-29-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN. 1, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CRISFIELD CEMETERY</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BRADSHAW + SONS, CRISFIELD, MD.</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <b>JAN 4 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

(M)

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FOR STATE  
HEALTH DEPT. **M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME  
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13800

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13279

1. PLACE OF DEATH a. COUNTY <b>Dorchester, Co.</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Maryland</b> c. LENGTH OF STAY IN lb <b>1 Month</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Street</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester, Co.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Church Creek, Maryland.</b> d. STREET ADDRESS <b>None</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Maggie Smith Elzey</b>				4. DATE OF DEATH Month <b>12</b> Day <b>10</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/3/1877</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>12</b> Days <b>10</b>		IF UNDER 24 HRS. Hours <b>10</b> Min. <b>19</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Seward's, Maryland.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Robert Smith</b>			
14. MOTHER'S MAIDEN NAME <b>Margaret Smith</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>No</b>				17. INFORMANT <b>Mrs. Nettie Robinson, Washington St. Cambridge, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>3</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>3</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Mace Jr.</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>12/12/1960</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>				22d. LOCATION (City, town, or country) (State) <b>Cambridge, Maryland.</b>			
23. FUNERAL DIRECTOR <b>Le Compte Funeral Service, Cambridge, Maryland.</b>				24. REC'D BY REGISTRAR <b>DEC 22 '60</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanks</b>							

MEDICAL CERTIFICATION

1988

10-21-88

Washington Street  
1000

11/1/87

U.S.A.

Washington St.

05/1/87

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <div style="text-align: center; font-weight: bold;">Dorchester</div> <b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center;">Near. Cambridge</div> <b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <div style="text-align: center;">Eastern Shore State Hospital</div>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution; Residence before admission) <b>a. STATE</b> <div style="text-align: center; font-weight: bold;">Maryland</div> <b>b. COUNTY</b> <div style="text-align: center; font-weight: bold;">Wicomico</div> <b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-weight: bold;">Salisbury</div> <b>d. STREET ADDRESS</b> <div style="text-align: center; font-weight: bold;">608 N. Pinehurst Ave.</div>	
<b>3. NAME OF DECEASED</b> (Type or print) <div style="text-align: center; font-weight: bold;">Nettie Scarff Emmoor</div>		<b>4. DATE OF DEATH</b> <div style="text-align: center;">December 4th. 1960</div>	
<b>5. SEX</b> <div style="text-align: center; font-weight: bold;">Female</div>	<b>6. COLOR OR RACE</b> <div style="text-align: center; font-weight: bold;">White</div>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <div style="text-align: center; font-weight: bold;">7/19/70</div>
<b>9a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <div style="text-align: center; font-weight: bold;">Retired, House work</div>	<b>9b. KIND OF BUSINESS OR INDUSTRY</b> <div style="text-align: center; font-weight: bold;">own home</div>	<b>10. BIRTHPLACE</b> (State or foreign country) <div style="text-align: center; font-weight: bold;">Maryland</div>	<b>11. CITIZEN OF WHAT COUNTRY?</b> <div style="text-align: center; font-weight: bold;">U. S. A.</div>
<b>12. FATHER'S NAME</b> <div style="text-align: center; font-weight: bold;">William Burton</div>		<b>13. MOTHER'S MAIDEN NAME</b> <div style="text-align: center; font-weight: bold;">1st name unknown, Kirby</div>	
<b>14. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <div style="text-align: center; font-weight: bold;">No</div>		<b>15. SOCIAL SECURITY NO.</b> <div style="text-align: center; font-weight: bold;">Unknown</div>	
<b>16. INFORMANT</b> <div style="text-align: center; font-weight: bold;">Records, Eastern Shore State Hospital</div>			
<b>17. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <div style="text-align: center; font-weight: bold;">Terminal Broncho-pneumonia</div>  <div style="margin-top: 10px;"> <b>442X</b> DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.         </div> <div style="margin-top: 10px;"> <b>(b)</b> Arterio sclerotic Cardio-vascular renal disease with congestive failure - - - - -  <b>(c)</b> Arteriosclerosis, generalized         </div> </div> <div style="width: 15%; text-align: center;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <div style="font-weight: bold;">4 days</div>   <div style="font-weight: bold;">10 days</div>  <div style="font-weight: bold;">4 yrs.+</div> </div> </div>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <div style="text-align: center; font-weight: bold;">Fracture of neck of left femur, 6/30/60</div>			
<b>18a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input checked="" type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>18b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <div style="text-align: center; font-weight: bold;">Deceased slipped and fell to the floor fracturing left femur</div>	
<b>19a. TIME OF INJURY</b> Month, Day, Year <div style="text-align: center; font-weight: bold;">? a.m. 6/30/60 19</div>	<b>19b. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	<b>19c. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg, etc.) <div style="text-align: center; font-weight: bold;">E. S. S. Hospital</div>	
<b>20. (City or town)</b> <div style="text-align: center; font-weight: bold;">Nr. Cambridge, Dorchester, Md.</div>		<b>20. (County)</b> <div style="text-align: center; font-weight: bold;">Dorchester</div>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
<b>22. ACTUAL SIGNATURE</b> <div style="text-align: center; font-weight: bold;">Eldridge H. Wolff</div>		<b>23. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>24. EXAMINER'S NAME</b> (Type) <div style="text-align: center; font-weight: bold;">Eldridge H. Wolff, M. D. Cambridge, Md.</div>		<b>25. DATE SIGNED</b> <div style="text-align: center; font-weight: bold;">12/4/60</div>	
<b>26. BURIAL, CREMATION, REMOVAL</b> (Specify) <div style="text-align: center; font-weight: bold;">BURIAL</div>		<b>27. DATE THEREOF</b> <div style="text-align: center; font-weight: bold;">12-6-60</div>	
<b>28. NAME OF CEMETERY OR CREMATORY</b> <div style="text-align: center; font-weight: bold;">Waugh Methodist Cemetery</div>		<b>29. LOCATION</b> (City, town, or country) <div style="text-align: center; font-weight: bold;">Glen Arm, Md</div>	
<b>30. FUNERAL DIRECTOR</b> <div style="text-align: center; font-weight: bold;">William Cook, Inc.</div>		<b>31. ADDRESS</b> <div style="text-align: center; font-weight: bold;">1217 St. Paul Street</div>	
<b>32. REC'D BY REGISTRAR</b> <div style="text-align: center; font-weight: bold;">DEC 6 '60</div>		<b>33. REGISTRAR'S SIGNATURE</b> <div style="text-align: center; font-weight: bold;">Arthur S. Kraus</div>	



William Cook, Inc. - 1217 N. 1st Street

12-1-20

John H. McDonald Secretary

Jan 1, 1921

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13824 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13782

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>2 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>E.S.State Hospital</b>		d. STREET ADDRESS <b>102 Van Buren St.</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Charles</b> Last <b>Gochnour</b>		4. DATE OF DEATH Month <b>12-</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/9/72</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland Osterburg, Pa.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown Moses Gochnour</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown Margaret Wyant</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Mr. Charles Gochnour (Son) Salisbury, Maryland</b> <b>Records E.S.S.Hosp. Cambridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Noturol causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Mace Jr. Cambridge, Md.</b>		DATE SIGNED <b>12/10/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 13, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>DEC 13 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Fraw</b>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# 13801 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13783

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Dorchester, Co.</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b> <b>Life</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Bay View, Ave.,</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester, Co.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Maryland.</b> d. STREET ADDRESS <b>Bay View, Ave.,</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Harry M. Handy</b> First Middle Last				<b>4. DATE OF DEATH</b> <b>12 13 19 60</b> Month Day Year			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>1/29/1892</b>	
<b>9. AGE</b> (In years last birthday) <b>68</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>12</b> Days <b>13</b>		<b>IF UNDER 24 HRS.</b> Hours <b>19</b> Min. <b>60</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Custodian</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Custodian</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>							
<b>13. FATHER'S NAME</b> <b>Samuel B. Handy</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Margart Hurlock</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>				<b>16. SOCIAL SECURITY NO.</b> <b>218-05-1297</b>		<b>17. INFORMANT</b> <b>Mr. Harry Handy Jr.</b> <b>Ham Brooks Blvd. Cambridge</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>420.1</b> (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>John Mace Jr.</i> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME</b> (Type) <b>John Mace Jr. M.D.</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
				<b>DATE SIGNED</b> <b>12/15/60</b>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>12/16/1960.</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Dorchester Memorial Park</b>		<b>22d. LOCATION</b> (City, town, or country) (State) <b>Cambridge, Maryland.</b>	
<b>23. FUNERAL DIRECTOR</b> <b>Le Compte Funeral Service, Cambridge, Maryland.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DEC 22 '60</b> <b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Hume</i>			

MEDICAL CERTIFICATION

1938

13804

DEPARTMENT OF HEALTH

OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

IN SENATE

January 1, 1938

REPORT OF THE

COMMISSIONER OF HEALTH

FOR THE YEAR 1937

ALBANY

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PRINTED BY THE

STATE OF NEW YORK

PRINTING OFFICE

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13823  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

Reg. Dist. No. 13784

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CAMBRIDGE</u>				c. LENGTH OF STAY IN 1b <u>2 YRS 5 MO 5</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPI.</u>				d. STREET ADDRESS <u>20X-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM BLUNT HARPER</u>				4. DATE OF DEATH Month Day Year <u>DEC. 21 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 7, 1875</u>		9. AGE (In years lost birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN C. HARPER</u>				14. MOTHER'S MAIDEN NAME <u>ROWENA AULD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>218-34-9054</u>		INFORMANT <u>MRS FLORENCE HARPER, ST. MICHAELS, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 YRS +</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY 1</u> , 19 <u>59</u> , to <u>DEC 21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>DEC 20</u> , 19 <u>60</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>George H. Longley</u> M.D. <u>BED 2, CAMBRIDGE, MD. 12/21/60</u>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>GEORGE H. LONGLEY</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/23/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ST. MICHAELS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Jameson C. Bull, St. Michaels, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

18852

LETTERS OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Dorchester, Co.</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester, Co.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Maryland.</b>			c. LENGTH OF STAY IN 1b <b>1 Week</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hospital</b>			d. STREET ADDRESS <b>815 Race, Street.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Robert</b> Last <b>Hubbard</b>			4. DATE OF DEATH Month <b>12</b> Day <b>26</b> Year <b>19 60</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>9/2/1874</b>		9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>12</b> Days <b>26</b> Hours <b>19</b> Min. <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer &amp; Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer &amp; Waterman</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester, Co. Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Samuel Hubbard</b>		14. MOTHER'S MAIDEN NAME <b>Julia Spedden</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mr. Curtis S. Hubbard, Cambridge, Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral hemorrhage</b> DUE TO (c) <b>Hypertensive cardio-vascular-renal disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>7 days</b> <b>1 yr. +</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prostatic hypertrophy &amp; partial urinary obstruction; duration unknown</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>None. - - -</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None. - - -</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. - - 19 p. m. - - -		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - - - -	
20f. (City or town) - - - - -		20g. (County) - - - - -		20h. (State) - - - - -	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 19th. 1960</b> to <b>Dec. 26th. 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec. 26th. 1960</b> , and that death occurred at <b>2:00PM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Eldridge H. Wolff</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Dec. 28th. 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Eldridge H. Wolff, M. D.</b>		22d. ADDRESS <b>15 Locust st. Cambridge, Dorchester Co. Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/28/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Speddens Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Cambridge, Maryland, R.F.D. 3</b>		23e. (State) <b>MD</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service, Cambridge, Maryland.</b>		ADDRESS <b>Le Compte Funeral Service, Cambridge, Maryland.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 3 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles E. H.</b>		25c. REGISTRAR'S NAME <b>Charles E. H.</b>			

UNITED STATES DEPARTMENT OF HEALTH  
AND HUMAN SERVICES  
CENTRIFUGAL OF DEATH

19802

1. Name of deceased: [illegible]

2. Date of death: [illegible]

3. Place of death: [illegible]

4. Cause of death: [illegible]

5. Manner of death: [illegible]

6. Signature of physician: [illegible]

7. Signature of medical examiner: [illegible]

8. Signature of coroner: [illegible]

9. Signature of registrar: [illegible]

10. Signature of funeral director: [illegible]

11. Signature of undertaker: [illegible]

12. Signature of cemetery: [illegible]

13. Signature of burial: [illegible]

14. Signature of interment: [illegible]

15. Signature of cremation: [illegible]

16. Signature of other: [illegible]

17. Signature of witness: [illegible]

18. Signature of official: [illegible]

19. Signature of registrar: [illegible]

20. Signature of official: [illegible]

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

13826  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13786

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Galestown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Galestown</b>			
c. LENGTH OF STAY IN 1b <b>4 months</b>				d. STREET ADDRESS <b>R.F.D. #3-Box 275A Seaford,</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>R.F.D. #3 Box 275A Seaford Del.</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Clarence Johnson</b>				4. DATE OF DEATH <b>Dec. 3 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 25, 1924</b>	
9. AGE (In years last birthday) <b>36</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Diesetter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Md. Plastics, Inc. Delaware</b>			
11. BIRTHPLACE (State or foreign country) <b>USA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Elmer Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Mae Burtelle</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes W. War II</b>				16. SOCIAL SECURITY NO. <b>216-14-9310</b>			
17. INFORMANT <b>Mae Belle Johnson</b>				Address <b>RT. 3 Bx. 275A Seaford, Del</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Mace Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <b>12/6/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/6/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Federalburg, Car. Md.</b>	
23. FUNERAL DIRECTOR <b>Paynter M. Watson</b>				ADDRESS <b>Seaford, Del.</b>			
24a. RECEIVED BY REGISTRAR <b>DEC 7 60</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>			

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1982-10-10

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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13827  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
13787

1. PLACE OF DEATH o. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		d. STREET ADDRESS <b>RFD # 2</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>William</b> Last <b>Krabill</b>		4. DATE OF DEATH Month <b>December</b> Day <b>8</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 8, 1867</b>
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Christian Krabill</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Krabill</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>RECORDS: EasternShore State Hospital</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Myocarditis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>16 days</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome associated with Senile Brain Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (s) (this hospital) attended the deceased from **11-22** 19**60**, to **12-8** 19**60**, that (s) (we) last saw the deceased alive on **12-8** 19**60**, and that death occurred at **1:10 P.M.**, from the causes and on the date stated above.

22a. SIGNATURE <b>Harry J. Crawford</b>	M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <b>Harry J. Crawford</b>	22d. ADDRESS <b>Eastern Shore State Hospital, Cambridge, Md.</b>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>buried</b>	23b. DATE THEREOF <b>Dec 11 60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Neaton</b>	23d. LOCATION (City, town, or county) (State) <b>Neaton Md</b>
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24. FUNERAL DIRECTOR'S SIGNATURE <b>J. V. Moore &amp; Son</b>	ADDRESS <b>Denton</b>	25a. REC'D BY REGISTRAR <b>DATE DEC 21 '60</b>	25b. REGISTRAR'S SIGNATURE <b>Cecil S. Thomas</b>
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CERTIFICATE OF DEATH

1885

WILLIAM J. BROWN

Male

White

1885

WILLIAM J. BROWN

WILLIAM J. BROWN

WILLIAM J. BROWN

WILLIAM J. BROWN

WILLIAM J. BROWN

WILLIAM J. BROWN

WILLIAM J. BROWN

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13828

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13788

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock - Rural</b>		c. LENGTH OF STAY IN 1b <b>1 1/2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near Shiloh</b>				d. STREET ADDRESS <b>319 West Central Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Frederick</b> Last <b>Lankford</b>				4. DATE OF DEATH Month <b>December</b> Day <b>4</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1916</b>		9. AGE (In years last birthday) <b>44 yrs.</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>4</b>	IF UNDER 24 HRS. Hours <b>4</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee Continental Can Co., Hurlock</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dorchester Co., Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Percy W. Lankford</b>				14. MOTHER'S MAIDEN NAME <b>Hattie Cannon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-12-1824</b>		17. INFORMANT <b>Percy W. Lankford, Hurlock, Maryland, R.F.D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A cidosis</b> DUE TO <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>25 yrs.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John Mace, Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Dec. 4, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 8, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR <b>DEC 7 2 60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
13803 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
13789										
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>209 Pine St.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b> d. STREET ADDRESS <b>209 Pine St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Earl Brown Mack</b>					4. DATE OF DEATH <b>Dec. 9 1960</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/14/1908</b>		9. AGE (In years last birthday) <b>52</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Malicah Mack</b>					14. MOTHER'S MAIDEN NAME <b>Mary J. Holland</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>217-30-7790</b>		17. INFORMANT <b>Mrs. Sina Cornish</b>		Address <b>Cambridge, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>?</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>John Mace Jr.</b> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/14/60</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>12/13/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Old Field Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Church Creek, Dor. Md.</b>	
23. FUNERAL DIRECTOR <b>Herbert St. Clair</b> ADDRESS <b>Cambridge, Md.</b>					24a. REC'D BY REGISTRAR <b>DEC 19 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Knecht</b>			

FOR STATE  
TAX USE ONLY

138001

DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*James M. [Signature]*



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13804

13790

1. PLACE OF DEATH a. COUNTY <b>Dorchester, Co.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester, Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Maryland.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Maryland.</b>			
c. LENGTH OF STAY IN 1b <b>17 Years</b>				d. STREET ADDRESS <b>High, St.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cavalier Apts.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>Lee</b> Last <b>Martin</b>				4. DATE OF DEATH Month <b>12</b> Day <b>7</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/5/1886</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>James City County, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Wilkinson</b>				14. MOTHER'S MAIDEN NAME <b>Hannah Martin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mrs. Robert Wegand, Glenburn Ave, Cambridge, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage Left</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>generalized arteriosclerosis</b> DUE TO <b>Hypertension</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>11/20</b> to <b>12/7</b> , 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>12/7</b> , 19 <b>60</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>W. H. Hawks</b>				22b. ADDRESS <b>Cambridge Maryland</b>			
22c. PHYSICIAN'S NAME (Type) <b>W. H. Hawks</b>				22d. DATE SIGNED <b>12/8/60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/9/1960.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>James City Chapel Cemetery, Norge, Virginia</b>		23d. LOCATION (City, town, or county) (State) <b>(State)</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service, Cambridge, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 9 '60</b>			
				25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>			



## CERTIFICATE OF DEATH

Reg. Dist. No.

13791

13829

1. PLACE OF DEATH o. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>				c. LENGTH OF STAY IN 1b <u>1 YEAR, 8 MO.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>				d. STREET ADDRESS <u>101 - 4<sup>th</sup> ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS AMES MASON</u>				4. DATE OF DEATH Month Day Year <u>DEC. 24 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 29, 1880</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING -</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MAJOR MASON</u>				14. MOTHER'S MAIDEN NAME <u>LIZZIE CLAYTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		INFORMANT <u>HOSPITAL RECORD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO-PNEUMONIA</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 12, 1959</u> to <u>DEC. 24, 1960</u> , that I last saw the deceased alive on <u>DEC. 24, 1960</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>EASTERN SHORE STATE HOSP.</u>							
ACTUAL SIGNATURE <u>Ettore De Filippis</u>		PHYSICIAN'S NAME (Type) <u>ETTORE DEFILIPPIS</u>					
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/27/60</u>		22c. NAME OF CEMETERY <u>PARKSLEY CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PARKSLEY, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Watson</u>		ADDRESS <u>Pocomoke Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinner</u>	

CERTIFICATE OF DEATH

13820

1-2-1900

1-2-1900

1-2-1900

1-2-1900

1-2-1900

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1-2-1900

## CERTIFICATE OF DEATH

Reg. Dist. No.

13792

13830

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Caroline</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Fisher Nursing Home</b>				d. STREET ADDRESS <b>05X-2</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Arthur John Messick</b>				4. DATE OF DEATH Month Day Year <b>Dec 24 19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24 1872</b>		9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Canner &amp; Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Robert M. Messick</b>				14. MOTHER'S MAIDEN NAME <b>Caroline S. Willis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Coronic Congestive Failure</b> <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>Generalized Atherosclerosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right Hemiplegia</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/21</b> , 19 <b>41</b> , to <b>12/24</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12/23</b> , 19 <b>60</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James B. Plummer</b> M.D.				ADDRESS (Street, city or town, state) <b>P.O. Box 158 Preston Md</b> DATE SIGNED <b>12/26/60</b>			
PHYSICIAN'S NAME (Type) <b>Hurdell B. Plummer MD</b>				<b>Preston Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/28/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Easton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. M. Waller</b> ADDRESS <b>Preston, Md/</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 29 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13805 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13793

1. PLACE OF DEATH a. COUNTY <b>Dorchester, Co.</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Maryland.</b> c. LENGTH OF STAY IN 1b <b>12 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge Maryland Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester, Co.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Maryland.</b> d. STREET ADDRESS <b>West End Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Howard G. Miller</b>		4. DATE OF DEATH Last Month Day Year <b>12 9 1960</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/25/1895</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fuel Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Geo. W. Miller</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Mrs. Flossie Miller, West End Ave, Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>5 Min.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12/12/60</b>			
ACTUAL SIGNATURE <b>John Mace Jr.</b> EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/12/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Cambridge, Maryland.</b>	
23. FUNERAL DIRECTOR <b>Le Compte Funeral Service, Cambridge, Maryland.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 22 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

2008

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
13794

1. PLACE OF DEATH a. COUNTY <b>Dorchester, Co.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester, Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woolfords, Maryland.</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>				d. STREET ADDRESS <b>None</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Beulah</b> Middle <b>Brooks</b> Last <b>Mills</b>				4. DATE OF DEATH Month <b>12</b> Day <b>1</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/25/1891</b>	
9. AGE (In years lost birthday) yrs. <b>69</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester, Co. Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jefferson Brooks</b>				14. MOTHER'S MAIDEN NAME <b>Miranda Parker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Mr. Roy B. Mills, Woolfords, Maryland.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Thrombotic Arteries</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Residual Paralysis Vocal Cord Rheumatoid Arthritis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>11/28</b> 19 <b>60</b> to <b>12/1</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>12/1</b> 19 <b>60</b> and that death occurred at <b>7:45</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>				22b. DATE <b>12/3/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>W. H. HANKS M.D.</b>				22d. ADDRESS <b>CAMBRIDGE MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>12/4/1960.</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park.</b>				23d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service, Cambridge, Maryland;</b>				25a. REC'D BY REGISTRAR <b>DEC 9 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>							

MASSACHUSETTS DEPARTMENT OF HEALTH  
DIVISION OF PREVENTIVE MEDICINE  
BOSTON, MASSACHUSETTS 02111

*(continued)*

27. 10. 1904

*Reverend Sir*

the whole family is now in the hands of the Lord

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may be readily obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

13832

13795

1. PLACE OF DEATH a. COUNTY <b>Dorchester, Co.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester, Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Maryland R.F.D.#3</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>J.</b> Middle <b>Edward</b> Last <b>Mowbray</b>				4. DATE OF DEATH Month <b>12</b> Day <b>25</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/4/1880</b>	
9. AGE (In years lost birthday) <b>80</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester, Co. Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Luther Mowbray</b>				14. MOTHER'S MAIDEN NAME <b>Julia Mowbray</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mrs. J. Edward Mowbray, R.F.D.#3 Cambridge, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Liver</b> <b>156.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Viral infection</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 Mos</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/5</b> 19 <b>60</b> to <b>12/25</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>12/25</b> 19 <b>60</b> , and that death occurred at <b>A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>				22b. DATE SIGNED <b>12/26/60</b>		22c. PHYSICIAN'S NAME (Type) <b>W. H. HANKS, M.D.</b>	
22d. ADDRESS <b>CAMBRIDGE MARYLAND</b>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/28/1960.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spedden Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland. R.F.D.# 3</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service, Cambridge, Maryland.</b>				25a. REC'D BY REGISTRAR <b>JAN 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card in papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>		c. LENGTH OF STAY IN 1b <b>9 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTERN SHORE STATE HOSP.</b>		d. STREET ADDRESS <b>20X-2</b>	
3. NAME OF DECEASED (Type or print) First <b>ETHEL</b> Middle <b>MAY</b> Last <b>PAGE</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>25</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 15, 1884</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWORK</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DAWSON BALL</b>		14. MOTHER'S MAIDEN NAME <b>EVA HUNT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>HOSPITAL RECORD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF RECTUM</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CHRONIC CARDIOVASCULAR DISEASE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>DEC. 16, 1960</b> to <b>DEC. 24, 1960</b> , that (I) (we) last saw the deceased alive on <b>DEC. 24, 1960</b> , and that death occurred at <b>8:10 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Ettore De Filippis</b> M.D.		22b. DATE SIGNED <b>DEC. 25, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>ETTORE DEFILIPPIS</b>		22d. ADDRESS <b>EASTERN SHORE STATE HOSP.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/27/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>METHODIST CEMT.</b>		23d. LOCATION (City, town, or county) (State) <b>TILGHMAN, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Frank...</b>		25a. REC'D BY REGISTRAR <b>DEC 29 '60</b>	
ADDRESS <b>ST. MICHAEL'S...</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>	

CERTIFICATE OF DEATH

13833

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AND SEX

DATE OF BIRTH

PLACE OF BIRTH

NO

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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DATE OF DEATH

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13807

13793

1. PLACE OF DEATH o. COUNTY <b>Dorchester, Co.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>New Jersey</b> b. COUNTY <b>Mercer, Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Maryland.</b>				c. LENGTH OF STAY IN 1b <b>2 Weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>Linthicum</b> Last <b>Pasko</b>				4. DATE OF DEATH Month <b>12</b> Day <b>14</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/5/1932</b>	
9. AGE (In years last birthday) <b>28</b> yrs.		10. UNDER 1 YEAR Months <b>2</b> Days <b>28</b> Hours <b>0</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Dorchester, Co. Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Secretary</b>			
13. FATHER'S NAME <b>Thomas G. Linthicum</b>				14. MOTHER'S MAIDEN NAME <b>Agnes Tyler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-28-8541</b>		17. INFORMANT <b>Mr. Mike D. Pasko, 802 Liberty, St. Trenton, N.J.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Septicemia - Trauma</b> 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Septicemia</b> DUE TO (c) <b>Pyelonephritis &amp; Toxic Pregnancy 4 yrs ago</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pyelonephritis &amp; Toxic Pregnancy 4 yrs ago</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-25</b> 19 <b>60</b> to <b>12-14</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>12-14</b> 19 <b>60</b> , and that death occurred at <b>12:15</b> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>W. Benmann</b>				22b. DATE SIGNED <b>12-16-60</b>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/16/1960.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Old Trinty Church Yard</b>		23d. LOCATION (City, town, or county) (State) <b>Chruch Creek, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service, Cambridge, Maryland.</b>				25a. REC'D BY REGISTRAR <b>DATE DEC 22 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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• *ed. 2014/2015*



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Dorchester, Co.</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Maryland.</b>		c. LENGTH OF STAY IN lb <b>27 Years</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Dorchester, Co.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>120 Glasgow, Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. DATE OF DEATH Month <b>12</b> Day <b>15</b> Year <b>1960</b>		g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Maryland.</b>		h. STREET ADDRESS <b>120 Glasgow, Street</b>	
3. NAME OF DECEASED (Type or print) <b>Gertrude Seymour Pete</b>		4. SEX <b>Female</b>		5. COLOR OR RACE <b>White</b>		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. DATE OF BIRTH <b>4/3/1897</b>	
8. AGE (In years last birthday) <b>63</b> yrs.		9. IF UNDER 1 YEAR Months <b>12</b> Days <b>15</b> Hours <b>15</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seamstress</b>		11. BIRTHPLACE (State or foreign country) <b>Wooniskey Vermont</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George Seymour</b>		14. MOTHER'S MAIDEN NAME <b>Elma Seymour</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Mr. Pete, 120 Glasgow, St. Cambridge, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>John Mace Jr. M.D.</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>12/19/60</b>	
EXAMINER'S NAME (Type)		DATE SIGNED		Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/20/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		22d. LOCATION (City, town, or country) <b>Cambridge, Maryland.</b>		(State)	
23. FUNERAL DIRECTOR <b>Le Compte Funeral Service, Cambridge, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 22 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Hanna</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13809

CERTIFICATE OF DEATH

13800

1. PLACE OF DEATH a. COUNTY <b>Dorchester, Co.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester, Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Maryland.</b>		c. LENGTH OF STAY IN 1b <b>7 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>120 Wills, Street.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Addie</b> Middle <b>Simmons</b> Last <b>Phillips</b>		4. DATE OF DEATH Month <b>12</b> Day <b>15</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/2/1879</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR: Months <b>12</b> Days <b>15</b> Hours <b>19</b> Min. <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Le Compte Funeral Service, Records.</b>		Address <b>Cambridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Senility</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 hours</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary tuberculosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/13</b> to <b>12/15</b> 19 <b>60</b> , that (I) (we) lost saw the deceased alive on <b>12/15</b> 19 <b>60</b> and that death occurred on <b>12/15</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>W. H. Hanks</b>		22b. DATE SIGNED <b>12/17/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. H. HANKS, M.D.</b>		22d. ADDRESS <b>CAMBRIDGE, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/17/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service, Cambridge, Maryland.</b>		25a. REC'D BY REGISTRAR <b>DEC 22 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

代名主

*[Faint handwritten notes]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13834

13802

<b>1. PLACE OF DEATH</b> o. COUNTY <u>DORCHESTER</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>				d. STREET ADDRESS <u>2040-2</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>LULU BARBARA PITTENHOUSE</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>DECEMBER 3 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 15 1879</u>	
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>JAMES HUTCHISON</u>				14. MOTHER'S MARDEN NAME <u>SUSANNA SANGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-14-4513</u>		17. INFORMANT <u>HOSPITAL RECORDS</u> Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL HEMORRHAGE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 HRS.</u> <u>3 WEEKS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <u>FEB 19 1955</u> to <u>DEC 3 1960</u> , that (I) (we) last saw the deceased alive on <u>DEC 3 1960</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Harry J. Crawford</u> M.D.				22b. DATE SIGNED <u>DEC 3, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>HARRY J. CRAWFORD</u>				22d. ADDRESS <u>CAMBRIDGE, MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 6, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Barrows</u>		23d. LOCATION (City, town, or county) (State) <u>Cordova Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ellis Clark</u> ADDRESS <u>Easton, Md</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 8 '60</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Harris</u>	





TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13810

13803

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER, CO.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER, CO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE, MARYLAND.</b>		c. LENGTH OF STAY IN lb <b>1 WEEK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT. HOLLY, MARYLAND.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CAMBRIDGE MARYLAND HOSPITAL</b>				d. STREET ADDRESS <b>NONE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>E.</b> Last <b>ROBERSON</b>				4. DATE OF DEATH Month <b>12</b> Day <b>31</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/14/1883</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES B. ROBERSON</b>				14. MOTHER'S MAIDEN NAME <b>FANNIE THOMAS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>216-18-8944</b>		17. INFORMANT <b>MRS. JEAL LEWIS, CAMBRIDGE, MARYLAND.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 4 43X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Hypertensive Cardio Vascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uremia</b>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-21-57</b> 19____, to <b>12-31-60</b> 19____, that (I) (we) last saw the deceased alive on <b>12-31-60</b> 19____, and that death occurred at <b>5:15 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Albert E. Bunker</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-3-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Albert E. Bunker, M. D.</b>				22d. ADDRESS <b>200 Maryland Ave., Cambridge, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/2/1961.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BAPTIST CHURCH YARD</b>		23d. LOCATION (City, town, or county) (State) <b>WOOLFORD, MARYLAND.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>LE COMPTE FUNERAL SERVICE, CAMBRIDGE, MARYLAND.</b>				25a. REC'D BY REGISTRAR <b>JAN 9 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

1941

NAME OF DECEASED		DATE OF DEATH	
LAST NAME, FIRST NAME, MIDDLE NAME		MONTH DAY YEAR	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARITAL STATUS		PLACE OF BIRTH	
DATE OF BIRTH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
NAME OF SIGNER		NAME OF SIGNER	
TITLE OF SIGNER		TITLE OF SIGNER	
ADDRESS OF SIGNER		ADDRESS OF SIGNER	
CITY OF SIGNER		CITY OF SIGNER	
STATE OF SIGNER		STATE OF SIGNER	
ZIP CODE OF SIGNER		ZIP CODE OF SIGNER	
COUNTRY OF SIGNER		COUNTRY OF SIGNER	
DATE OF DEATH		DATE OF DEATH	
PLACE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
NAME OF SIGNER		NAME OF SIGNER	
TITLE OF SIGNER		TITLE OF SIGNER	
ADDRESS OF SIGNER		ADDRESS OF SIGNER	
CITY OF SIGNER		CITY OF SIGNER	
STATE OF SIGNER		STATE OF SIGNER	
ZIP CODE OF SIGNER		ZIP CODE OF SIGNER	
COUNTRY OF SIGNER		COUNTRY OF SIGNER	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 13804

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>38 Park Lane</b>		e. STREET ADDRESS <b>38 Park Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Lyle</b> Last <b>Saunders</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>24</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 23, 1889</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR: Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min. <b>71</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Dorchester County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Saunders</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Pinkett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-38-0384</b>	
17. INFORMANT <b>Maryetta Saunders, Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphysema</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1, 1960</b> , to <b>Dec 24, 1960</b> , that I last saw the deceased alive on <b>December 24, 1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. Edwin Fassett</b>		ADDRESS (Street, city or town, state) <b>227 Pine St., Cambridge, Md.</b>	
DATE SIGNED <b>12-27-60</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/28/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Waugh Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hubert M. Bellamy</b>		ADDRESS <b>Cambridge, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAN 3 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton E. Kraus</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED George Washington		SEX Male	
DATE OF BIRTH 1890		PLACE OF BIRTH Baltimore, Md.	
DATE OF DEATH 1917		PLACE OF DEATH Baltimore, Md.	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH Heart Disease	
DISEASE OR INJURY Myocardial Infarction		MEDICAL HISTORY None	
OCCUPATION Clerk		MARITAL STATUS Single	
EDUCATION High School Graduate		RELIGION Protestant	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13835 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 4 Filing 279 1-24-61 et											
1. PLACE OF DEATH a. COUNTY <u>Dorchester, Co.</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester, Co.</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland.</u>					c. LENGTH OF STAY IN 1b <u>Life</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>None</u>					e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md. R.F.D.# 3</u>						
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					d. STREET ADDRESS <u>None</u>						
3. NAME OF DECEASED (Type or print) <u>Franklin Seward</u>					4. DATE OF DEATH Month <u>Dec.</u> Day <u>Unknown</u> Year <u>1960</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1893</u>		9. AGE (in years last birthday) <u>67</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>213-22-6944</u>					17. INFORMANT Address <u>LeCompte Funeral Home, Cambridge, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exposure</u> 932.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found frozen in yard of his home.</u>								INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>Unknown</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Yard, home</u>		20f. (City or town) (County) (State) <u>Cambridge Dor. Md.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John Mace Jr.</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <u>John Mace Jr. M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1/10/61</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>12/31/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Cambridge, Dor. Md.</u>		
23. FUNERAL DIRECTOR <u>Le Compte Funeral Service, Cambridge, Maryland.</u>					ADDRESS <u>Le Compte Funeral Service, Cambridge, Maryland.</u>					24a. REC'D BY REGISTRAR <u>JAN 17 '61</u>	
					24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>						

1913 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

City of New York, N.Y.

1913

13-32-3011

*Handwritten signature*



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13812

CERTIFICATE OF DEATH

Reg. Dist. No.

13806

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN lb <b>13 hrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>Alfred</b> Last <b>Stanley Jr.</b>				4. DATE OF DEATH Month <b>December</b> Day <b>12</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 11, 1960</b>	
9. AGE (In years last birthday) <b>13</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Raymond Alfred Stanley</b>			
14. MOTHER'S MAIDEN NAME <b>Virginia Mae Stewart</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>none</b>				17. INFORMANT <b>Virginia Stanley-18 Douglas Street-Cambridge, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776X</b> DUE TO <b>Pneumonia (at 11 7 3)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>13 hours</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <b>12-11-</b> _____, 19 <b>60</b> , to <b>12-12-</b> _____, 19 <b>60</b> , that I last saw the deceased alive on <b>12-12-</b> _____, 19 <b>60</b> , and that death occurred at <b>3:15A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>				ADDRESS (Street, city or town, state) <b>227 Pine St. Cambridge, Maryland</b>			
DATE SIGNED _____				M.D. <b>227 Pine St. Cambridge, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Dr. J. Edwin Fassett</b>				<b>- 227 Pine Street Cambridge, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>12-12-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cambridge Maryland Hospital</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE _____ ADDRESS _____				24a. REC'D BY REGISTRAR DATE <b>DEC 19 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2067288XVO



DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13836

13807

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>2yr. 6mo. 8das.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>				d. STREET ADDRESS <b>Gandy Lane</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Ethel</b> Middle <b>-</b> Last <b>Sterling</b>				4. DATE OF DEATH Month <b>December</b> Day <b>6</b> Year <b>1960</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-4-74</b>	
9. AGE (In years (last birthday) yrs. <b>86</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Isaac Ross Sterling</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ellen Bradshaw</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>212-10-4687</b>		17. INFORMANT Address <b>RECORDS - Eastern Shore State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Bronchopneumonia</b> DUE TO <b>Chronic Cardiovascular Disease</b> (b) <b>General Arteriosclerosis</b> DUE TO <b>General Arteriosclerosis</b> (c) <b>General Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 29</b> 19 <b>58</b> , to <b>Decem. 6</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Dec. 6</b> 19 <b>60</b> , and that death occurred at <b>10:08</b> A. M., from the causes and on the date stated above.							
22a. SIGNATURE <b>E. DeFilippis</b> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Dr. E. DeFilippis</b>				22d. ADDRESS <b>E.S.S. Hospital, Cambridge, Md. 12-6-60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 8, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crisfield</b>		23d. LOCATION (City, town, or county) (State) <b>Crisfield, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Harvey Bradshaw</b> ADDRESS <b>Crisfield, Md</b>				25a. REC'D BY REGISTRAR <b>DEC 12 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Kneale</b>	

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
ALBANY, N. Y.  
JAN 10 1900  
TO THE HONORABLE THE COMMISSIONERS OF THE LAND OFFICE  
SIR:  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the application of the State of New York for a lease of the land in the town of ...  
and in reply to inform you that the same has been referred to the proper authorities for their consideration.  
Very respectfully,  
J. B. ...  
Attorney General

1

RECEIVED  
JAN 10 1900  
OFFICE OF THE ATTORNEY GENERAL  
ALBANY, N. Y.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

# CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WICOMICO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>		c. LENGTH OF STAY IN 1b <b>1 YEAR, 4 Mo.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTERN SHORE STATE HOSP.</b>		d. STREET ADDRESS <b>231 22</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HERMAN GEORGE TAYLOR</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>24</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 8, 1881</b>
9. AGE (In years lost birthday) yrs. <b>79</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWNER</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE HANDY TAYLOR</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE VIRGINIA LYNCH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>230-10-8188</b>	
17. INFORMANT <b>HOSPITAL RECORD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>GENERAL ARTERIOSCLEROSIS</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>AUG. 18, 1957</b> to <b>DEC. 24, 1960</b> , that (I) (we) last saw the deceased alive on <b>DEC. 24, 1960</b> , and that death occurred at <b>4:45 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Ettore DeFilippis</b> M.D.		22b. DATE SIGNED <b>12-24-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>ETTORE DEFILIPPIS</b>		22d. ADDRESS <b>EASTERN SHORE STATE HOSP.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-27-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Taylor Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson</b>		25. REGISTRAR'S SIGNATURE <b>Salisbury, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>DEC 28 1960</b>		25b. REGISTRAR'S SIGNATURE <b>Carolina E. H.</b>	





1. PLACE OF DEATH a. COUNTY <b>Dorchester</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, R.D. 1</b>		c. LENGTH OF STAY IN b. <b>25 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, R.D. 1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.F.D. 1</b>		d. STREET ADDRESS <b>R.F.D. 1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lillie May</b>		First <b>Cuddy</b>		Middle <b>Thorne</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>May 7, 1874</b>		9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	
11. BIRTHPLACE (County & State, or foreign country) <b>Joplin, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>William Cuddy</b>	
14. MOTHER'S MAIDEN NAME <b>Anna Latham</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Frank C. Thorne, Cambridge, Md., R.D. 1</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia</b> 450.1 DUE TO <b>Arteriosclerotic gangrene</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Rt lower extremities</b> (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>3 weeks</b> <b>7</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acidity</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Cambridge, Md.</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/24</b> <b>1960</b> to <b>12/23</b> <b>1960</b> ; that (I) (we) last saw the deceased alive on <b>12/23</b> <b>1960</b> , and that death occurred at <b>10:15 P.M.</b> from the causes and on the date stated above		22a. SIGNATURE <b>W. H. Hanks</b> M.D.		22b. DATE SIGNED <b>12/26/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. H. Hanks M.D.</b>		22d. ADDRESS <b>CAMBRIDGE, Md.</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 26, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>	
23d. LOCATION (City, town or county) <b>Cambridge, Md.</b>		23e. (State) <b>Md.</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth R. Shover</b>		24a. ADDRESS <b>Cambridge, Md.</b>		24b. REC'D BY REGISTRAR <b>JAN 3 1961</b>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13839

CERTIFICATE OF DEATH

Reg. Dist. No.

13810

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PART DEPOSIT</u>			
c. LENGTH OF STAY IN 1b <u>7 1/2 MONTHS</u>				d. STREET ADDRESS <u>07 X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CASIMIRO</u>		First Middle Last <u>TRIALIO</u>		4. DATE OF DEATH <u>DECEMBER 31</u>		Month Day Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 15 1877</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STONE QUARRY</u>		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNKNOWN</u>	
13. FATHER'S NAME <u>MICHAEL TRIALIO</u>				14. MOTHER'S MAIDEN NAME <u>PHILOMENA CAVALIER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		INFORMANT Address <u>HOSPITAL RECORDS.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>15 MINS</u> <u>3 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 17</u> , 19 <u>60</u> , to <u>DEC 31</u> , 19 <u>60</u> ; that I last saw the deceased alive on <u>DEC 30</u> , 19 <u>60</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Harry J. Crawford</u> M.D. <u>CAMBRIDGE, MD.</u>				DATE <u>DEC 31, 1960</u>			
PHYSICIAN'S NAME (Type) <u>HARRY J. CRAWFORD</u>							
22a. REMOVAL (Specify)		22b. DATE THEREOF <u>Jan 4 - 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U. Md. Anatomy Bldg</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth R. Thompson</u> ADDRESS <u>100 Locust St.</u>				24a. REC'D BY REGISTRAR <u>JAN 5 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

RECEIVED FROM THE OFFICE OF THE SECRETARY OF THE ARMY

OFFICE OF THE SECRETARY OF THE ARMY

1943

MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13813

## CERTIFICATE OF DEATH

Reg. Dist. No. 13812

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Fairmount Avenue</b>				d. STREET ADDRESS <b>Fairmount Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Oree</b> Middle <b>Selover</b> Last <b>Tyler</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>20</b> Year <b>1960</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 27, 1891</b>			
9. AGE (In years last birthday) <b>69</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Restaurant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Cambridge, Md.</b>			
13. FATHER'S NAME <b>John Tyler</b>				14. MOTHER'S MAIDEN NAME <b>Mattie St. Clair</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Mammie Bellemy, Washington, D. C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic CVD</b> DUE TO (c) <b>Arteriosclerosis gen.</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b> <b>?</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pul. Tb. - (inactive) 002X</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>Cambridge, Md.</b>				20g. (County) <b>Dorchester</b>		20h. (State) <b>Md.</b>			
21. I certify that I attended the deceased from <b>Dec 20, 1960</b> to <b>Dec 20, 1960</b> , that I last saw the deceased alive on <b>Dec 20, 1960</b> , and that death occurred at <b>Cambridge, Md.</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>[Signature]</b>				DATE SIGNED <b>12/29/60</b>					
PHYSICIAN'S NAME (Type) <b>[Signature]</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/26/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Waugh Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>				ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 3 '61</b>			
24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>									





may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13840  
CERTIFICATE OF DEATH  
13813

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crumpton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		d. STREET ADDRESS <b>-</b>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth (Bessie) Jones Warner</b>		4. DATE OF DEATH <b>December 13 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1880</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Jones</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-05-0275</b>	
17. INFORMANT <b>RECORDS: Eastern Shore State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Myocarditis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>10 hours</b> <b>Over 2 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome - Senile Brain Disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>July 25, 1958</b> to <b>Dec. 13, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec. 13, 1960</b> , and that death occurred at <b>10:45 P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Harry J. Crawford</b> M.D.		22b. DATE SIGNED <b>12-14-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harry J. Crawford, M.D.</b>		22d. ADDRESS <b>Eastern Shore State Hospital, Cambridge, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/17/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Stevensville</b>		23d. LOCATION (City, town, or county) (State) <b>Queen Anne Co. md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane Church Hill md</b>		25a. REC'D BY REGISTRAR <b>DEC 16 '60</b>	
		25b. REGISTRAR'S SIGNATURE <b>Robert S. Thomas</b>	

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CERTIFICATE OF DEATH

13840

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Secretary</u> X	
c. LENGTH OF STAY IN 1b <u>Two hrs</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>AMATA HURST WILLOUGHBY</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland</u>		5. DATE OF DEATH <u>12/20/1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/6/1886</u>
9. AGE (In years, months, days) <u>74</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Quadrone</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>John J. Hurst</u>	14. MOTHER'S MAIDEN NAME <u>Rebecca</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)	16. SOCIAL SECURITY NO. <u>William Willoughby Secretary Md</u>	17. INFORMANT <u>William Willoughby Secretary Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO <u>Coronary occlusion</u> (c) <u>420.1</u> DUE TO <u>Coronary occlusion</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN MACEJR</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/22/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		22d. LOCATION (City, town, or country) (State) <u>East New Market, Md</u>	
23. FUNERAL DIRECTOR <u>William Willoughby</u>		24a. REC'D BY REGISTRAR <u>Jan 3 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>William Willoughby</u>		DATE <u>12/27/60</u>	

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH 5 min

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

DATE SIGNED

12/27/60

51261

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13815

## CERTIFICATE OF DEATH

Reg. Dist. No. 13815

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>entire life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Byrn Street</b>		d. STREET ADDRESS <b>1 Byrn Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Brown</b> Last <b>Wright</b>		4. DATE OF DEATH Month <b>December</b> Day <b>9</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 27, 1882</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>18</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cambridge</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George R. Brown</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Wrightson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>	
17. INFORMANT <b>Miss Mable Wright, Byrn St., Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>331x</b> DUE TO <b>Cerebral hemorrhage.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Cerebral arteriosclerosis.</b> DUE TO <b>(c)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diaphragmatic hernia, Chronic arthritis, Cystocele</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 2, 1956</b> to <b>Dec 9, 1960</b> , that I last saw the deceased alive on <b>Dec 9, 1960</b> , and that death occurred at <b>8:05 P. M.</b> from the causes and on the date stated above.		DATE SIGNED <b>12/2/60</b>	
ACTUAL SIGNATURE <b>Albert E. Simler</b>		M.D. <b>200 Maryland Ave., Cambridge, Md.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 11, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Levinth R. Howard</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 15 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			



